FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039339

Facility Name: Jerseyville Nursing and Rehabilitation Center

Address: 1001 South State Street (Number) Jerseyville (City) 62052 (Zip Code)

County: Jersey

Telephone Number: (618) 498-6496 **Fax #** (618) 498-7435

IDPA ID Number: 37-1323741

Date of Initial License for Current Owners: 04/01/1994

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: J. Terry Dooling **Telephone Number:** (618) 465-7717

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) J. Terry Dooling
(Title) Treasurer

Paid Preparer

(Signed) See Accountants Compilation Report (Date)
(Print Name and Title) J. Terry Dooling, Partner
(Firm Name & Address) C.J. Schlosser & Company, L.L.C., 233 East Center Drive, Alton, IL 62002
(Telephone) (618) 465-7717 Fax # (618) 465-7710

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	101	Skilled (SNF)	101	36,966	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	101	TOTALS	101	36,966	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		10,530	5,733	16,263	8
9	SNF/PED					9
10	ICF	19,304			19,304	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,304	10,530	5,733	35,567	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.22%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Outpatient Therapy

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/1994

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/1994 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 101 and days of care provided 5,733

Medicare Intermediary Trispan Health Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	178,001	18,845	5,017	201,863		201,863		201,863			1
2	Food Purchase		197,265		197,265		197,265	(927)	196,338			2
3	Housekeeping	87,422	15,917		103,339		103,339		103,339			3
4	Laundry	81,773	18,907		100,680		100,680		100,680			4
5	Heat and Other Utilities			103,704	103,704		103,704	503	104,207			5
6	Maintenance	43,859	5,228	20,231	69,318		69,318	558	69,876			6
7	Other (specify):* Waste Removal			8,434	8,434		8,434		8,434			7
8	**TOTAL General Services**	391,055	256,162	137,386	784,603		784,603	134	784,737			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,266,622	92,343	20,746	1,379,711	123	1,379,834	(992)	1,378,842			10
10a	Therapy	37,073	409	339,188	376,670		376,670	(46,507)	330,163			10a
11	Activities	36,927	4,944	1,449	43,320	1,169	44,489		44,489			11
12	Social Services	57,528		1,449	58,977		58,977		58,977			12
13	Nurse Aide Training											13
14	Program Transportation		2,665		2,665		2,665		2,665			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,398,150	100,361	372,432	1,870,943	1,292	1,872,235	(47,499)	1,824,736			16
	C. General Administration											
17	Administrative	73,467	6,397	233,684	313,548	(1,886)	311,662	(158,656)	153,006			17
18	Directors Fees											18
19	Professional Services			60,121	60,121		60,121	(2,104)	58,017			19
20	Dues, Fees, Subscriptions & Promotions			29,761	29,761		29,761	(5,969)	23,792			20
21	Clerical & General Office Expenses	53,520	15,023	50,854	119,397		119,397	15,244	134,641			21
22	Employee Benefits & Payroll Taxes			262,407	262,407		262,407	12,118	274,525			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,582	7,582	250	7,832	10,035	17,867			24
25	Other Admin. Staff Transportation							5,881	5,881			25
26	Insurance-Prop.Liab.Malpractice			47,009	47,009		47,009	1,098	48,107			26
27	Other (specify):*											27
28	**TOTAL General Administration**	126,987	21,420	691,418	839,825	(1,636)	838,189	(122,353)	715,836			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,916,192	377,943	1,201,236	3,495,371	(344)	3,495,027	(169,718)	3,325,309			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center #0039339 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			178,458	178,458		178,458	3,509	181,967			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			306,745	306,745		306,745	(8,788)	297,957			32
33	Real Estate Taxes			52,246	52,246		52,246	573	52,819			33
34	Rent-Facility & Grounds							3,828	3,828			34
35	Rent-Equipment & Vehicles			2,917	2,917		2,917	779	3,696			35
36	Other (specify):* Mortgage Ins.			18,139	18,139		18,139		18,139			36
37	**TOTAL Ownership**			558,505	558,505		558,505	(99)	558,406			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		157,086	34,570	191,656		191,656		191,656			39
40	Barber and Beauty Shops					344	344		344			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,450	55,450		55,450		55,450			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		157,086	90,020	247,106	344	247,450		247,450			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,916,192	535,029	1,849,761	4,300,982		4,300,982	(169,817)	4,131,165			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(493)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,086)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,725)	20		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(14)	20		18
19	Entertainment	(1,456)	24		19
20	Contributions	(424)	17		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,489)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(4,898)	Var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (12,585)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(157,232)	Var	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (157,232)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (169,817)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops	X		344	17	41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$ 344		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Jerseyville Nursing and Rehabilitation Center

ID# 0039339

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset misc income against expense	$ (434)	2	1
2	Offset misc income against expense	(992)	10	2
3	Eliminate PAC & lobbying dues	(2,218)	20	3
4	Eliminate additional meals & entertainment	(1,254)	17	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(4,898)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(927)	0	0	0	0	0	0	0	0	0	0	(927)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	503	0	0	0	0	0	0	0	0	0	503	5
6	Maintenance	0	558	0	0	0	0	0	0	0	0	0	558	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(927)	1,061	0	0	0	0	0	0	0	0	0	134	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(992)	0	0	0	0	0	0	0	0	0	0	(992)	10
10a	Therapy	0	0	(46,507)	0	0	0	0	0	0	0	0	(46,507)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(992)	0	(46,507)	0	0	0	0	0	0	0	0	(47,499)	16
	C. General Administration													
17	Administrative	(1,678)	76,706	(233,684)	0	0	0	0	0	0	0	0	(158,656)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,316	(3,420)	0	0	0	0	0	0	0	0	(2,104)	19
20	Fees, Subscriptions & Promotions	(6,446)	477	0	0	0	0	0	0	0	0	0	(5,969)	20
21	Clerical & General Office Expenses	0	15,244	0	0	0	0	0	0	0	0	0	15,244	21
22	Employee Benefits & Payroll Taxes	0	12,118	0	0	0	0	0	0	0	0	0	12,118	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,456)	11,491	0	0	0	0	0	0	0	0	0	10,035	24
25	Other Admin. Staff Transportation	0	5,881	0	0	0	0	0	0	0	0	0	5,881	25
26	Insurance-Prop.Liab.Malpractice	0	1,098	0	0	0	0	0	0	0	0	0	1,098	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(9,580)	124,331	(237,104)	0	0	0	0	0	0	0	0	(122,353)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(11,499)	125,392	(283,611)	0	0	0	0	0	0	0	0	(169,718)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	3,509	0	0	0	0	0	0	0	0	0	3,509	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,086)	0	(7,702)	0	0	0	0	0	0	0	0	(8,788)	32
33	Real Estate Taxes	0	573	0	0	0	0	0	0	0	0	0	573	33
34	Rent-Facility & Grounds	0	3,828	0	0	0	0	0	0	0	0	0	3,828	34
35	Rent-Equipment & Vehicles	0	0	779	0	0	0	0	0	0	0	0	779	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,086)	7,910	(6,923)	0	0	0	0	0	0	0	0	(99)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(12,585)	133,302	(290,534)	0	0	0	0	0	0	0	0	(169,817)	45

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
John H. Rothert	60.00	Montgomery Nursing & Rehabilitation Center	Hillsboro, IL	Wellington Mgt Co	Chesterfield, MO	Management Co.
David L. Kamler	15.00	Westwood Hills Health Care Center	Poplar Bluff, MO	Health Care Financial	Alton, IL	Management Co.
J. Terry Dooling	15.00	Spanish Lake Nursing & Rehabilitation Center	Florissant, MO	C.J. Schlosser & Co	Alton, IL	Public Accountants
Jack A. Yaeger	10.00			N.W. Rehab, L.L.C.	Alton, IL	Therapy Company
				Three Amigos of Spani	Alton, IL	Real Estate Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	See Schedule VIII	$	Wellington Management Co.	60.00%	$ 503	$ 503	1
2	V	6	See Schedule VIII		Wellington Management Co.	60.00%	558	558	2
3	V	17	See Schedule VIII		Wellington Management Co.	60.00%	76,706	76,706	3
4	V	19	See Schedule VIII		Wellington Management Co.	60.00%	1,316	1,316	4
5	V	20	See Schedule VIII		Wellington Management Co.	60.00%	477	477	5
6	V	21	See Schedule VIII		Wellington Management Co.	60.00%	15,244	15,244	6
7	V	22	See Schedule VIII		Wellington Management Co.	60.00%	12,118	12,118	7
8	V	24	See Schedule VIII		Wellington Management Co.	60.00%	11,491	11,491	8
9	V	25	See Schedule VIII		Wellington Management Co.	60.00%	5,881	5,881	9
10	V	26	See Schedule VIII		Wellington Management Co.	60.00%	1,098	1,098	10
11	V	30	See Schedule VIII		Wellington Management Co.	60.00%	3,509	3,509	11
12	V	33	See Schedule VIII		Wellington Management Co.	60.00%	573	573	12
13	V	34	See Schedule VIII		Wellington Management Co.	60.00%	3,828	3,828	13
14	Total			$			$ 133,302	$ * 133,302	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	See Schedule VIII	$	Wellington Management Co.	60.00%	$ 779	$ 779	15
16	V	10	Nurse Consultant	16,480	Wellington Management Co.	60.00%	16,480		16
17	V	17	Management Fees	167,890	Wellington Management Co.	60.00%		(167,890)	17
18	V	17	Management Fees	65,794	Health Care Financial, L.L.C.	40.00%		(65,794)	18
19	V	19	Professional Services	48,236	C.J. Schlosser & Company, L.L.C.	40.00%	44,816	(3,420)	19
20	V	10a	Therapy Services	339,188	NW Rehab, L.L.C.	100.00%	292,681	(46,507)	20
21	V	32	Interest	7,702	John H. Rothert	60.00%		(7,702)	21
22	V	10	Nurse Consultant	1,650	Montgomery Nursing & Rehabilitation Center, Inc.	0.00%	1,650		22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 646,940			$ 356,406	$ * (290,534)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Cente # 0039339 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	John H. Rothert	President	Administrative	60.00	206,358	8.8	22.00	Salary	$ 58,217	17,8	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 58,217		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Wellington Management Company
Street Address: 750 Spirit 40 Park Drive
City / State / Zip Code: Chesterfield, MO 63005
Phone Number: (636) 537-8447
Fax Number: (636) 537-8446

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Heat and Other Utilities	Accumulated Costs	16,892,315	5	$ 2,285	$	3,716,988	$ 503	1
2	6	Maintenance	Accumulated Costs	16,892,315	5	2,536		3,716,988	558	2
3	17	Administrative	Accumulated Costs	16,892,315	5	348,599	348,599	3,716,988	76,706	3
4	19	Professional Services	Accumulated Costs	16,892,315	5	5,982		3,716,988	1,316	4
5	20	Dues, Fees, Subs & Promos	Accumulated Costs	16,892,315	5	2,166		3,716,988	477	5
6	21	Clerical & General Office Exp.	Accumulated Costs	16,892,315	5	69,278	31,999	3,716,988	15,244	6
7	22	Employee Benefits & PR Taxes	Accumulated Costs	16,892,315	5	55,073		3,716,988	12,118	7
8	24	Travel & Seminar	Accumulated Costs	16,892,315	5	52,224		3,716,988	11,491	8
9	25	Other Admin. Staff Transport	Accumulated Costs	16,892,315	5	26,725		3,716,988	5,881	9
10	26	Insurance-Prop., Liab., Malprac.	Accumulated Costs	16,892,315	5	4,990		3,716,988	1,098	10
11	30	Depreciation	Accumulated Costs	16,892,315	5	15,946		3,716,988	3,509	11
12	33	Real Estate Taxes	Accumulated Costs	16,892,315	5	2,602		3,716,988	573	12
13	34	Rent - Facility & Grounds	Accumulated Costs	16,892,315	5	17,395		3,716,988	3,828	13
14	35	Rent - Equipment & Vehicles	Accumulated Costs	16,892,315	5	3,542		3,716,988	779	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 609,343	$ 380,598		$ 134,081	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Cente # 0039339 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	GMAC Commercial Mortgage		X	Mortgage Loan	$26,697.36	4/17/00	$ 3,720,700	$ 3,613,430	5/1/2035	8.1000	$ 293,865	1
2												2
3												3
4									Loan Cost Amortization		5,178	4
5									Interest Income Allocation		(1,086)	5
	Working Capital											
6	First National Bank		X	Line of Credit	N/A	1/4/04	100,000	1	1/4/05	prime+1%		6
7												7
8												8
9	TOTAL Facility Related				$26,697.36		$ 3,820,700	$ 3,613,431			$ 297,957	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,820,700	$ 3,613,431			$ 297,957	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 18,139** **Line # 36**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	43,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	47,246	2
3. Under or (over) accrual (line 2 minus line 1).	$	4,246	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	48,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	52,246	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	23,468	8
	2000	23,113	9
	2001	27,516	10
	2002	42,692	11
	2003	47,246	12

Line 2: 2003 Taxes Paid

Line 4: Accrual is based on 2003 taxes paid.

Line 7: $52,246 + $573 (Home Office R.E. Tax Allocation) = $52,819 Total R.E. Taxes-Schedule V, Col. 8

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Jerseyville Nursing and Rehabilitation Center COUNTY Jersey

FACILITY IDPH LICENSE NUMBER 0039339

CONTACT PERSON REGARDING THIS REPORT J. Terry Dooling

TELEPHONE (618) 465-7717 FAX #: (618) 465-7710

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-875-004-00	Outlots 59,62,63 & 64 S Pt Outlot 62	$ 43,999.42	$ 43,999.42
2.	04-208-017-00	S28 T8 R11 Unplatted Parcels	$ 3,246.62	$ 3,246.62
3.		S & W PT SE 1/4 NE 1/4 Less E PT	$	$
4.		Less .10 ACS for Hwy	$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 47,246.04	$ 47,246.04

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,948 B. General Construction Type: Exterior Brick & Siding Frame Steel & Brick Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs: N/A
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	158,994	1994	$ 71,664	1
2					2
3	TOTALS	158,994		$ 71,664	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	101		1994		$ 1,180,668	$ 47,227	25	$ 47,227	$	$ 507,687	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Parking Lot			1994	26,304	1,196	5-10	1,196		26,304	9
10	Exterior Remodeling			1994	10,000	667	15	667		7,056	10
11	Flooring			1994	29,698	1,807	10	1,807		29,698	11
12	Electrical			1994	11,690	585	20	585		5,988	12
13	Air Conditioning			1994	25,830	1,722	10	1,722		25,830	13
14	Interior Remodel			1994	40,265	1,359	5-20	1,359		33,613	14
15	Shed			1994	3,267	109	10	109		3,267	15
16	Nurses' Station			1994	6,055	303	20	303		3,204	16
17	Home Office Wallpapering/Flooring			1994	3,478		5			3,478	17
18	Painting			1995	7,392		5			7,392	18
19	Electrical			1995	3,382	338	10	338		3,326	19
20	Call Lights			1996	1,564	104	10	104		965	20
21	Storage Building			1996	3,500	350	10	350		2,800	21
22	2 Boilers			1996	7,400	370	20	370		3,299	22
23	Roof Repair & Drains Installed			1996	3,619	362	10	362		3,167	23
24	Ceiling Tile & End Caps			1996	3,506	292	12	292		2,386	24
25	Storage Building			1997	3,356	336	10	336		2,657	25
26	Alarm System			1997	1,750	175	10	175		1,385	26
27	Wallcovering			1997	6,355	318	5-10	318		5,613	27
28	Ceiling Tile			1997	1,485	124	12	124		928	28
29	3 Windows & Sills & 1 Door Replaced			1997	4,108	274	15	274		2,008	29
30	Baseboards Remodeled			1997	1,166	117	10	117		856	30
31	Air Conditioner Unit			1997	2,185	219	10	219		1,633	31
32	Concrete Patio & Sidewalk			1997	1,842	123	15	123		901	32
33	Rock			1997	502		5			502	33
34	Landscaping			1997	1,075	107	10	107		824	34
35	Roofing			1998	2,592	259	10	259		1,793	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Shower Room Remodeled	1998	$ 1,437	$ 144	10	$ 144	$	$ 994	37
38	Baseboard Remodeling	1998	1,919	192	10	192		1,271	38
39	Air Conditioning Units & Ducts	1998	13,420	1,280	10-20	1,280		8,299	39
40	Wallcoverings	1998	1,495	149	10	149		909	40
41	4 Air Conditioning Units	1999	2,840	284	10	284		1,538	41
42	Roofing	1999	35,386	3,539	10	3,539		20,347	42
43	Home Office Wallpapering	1999	585		5	20	20	585	43
44	3 Air Conditioning Units	2000	2,118	212	10	212		936	44
45	Wallcoverings	2000	2,231	446	5	446		1,970	45
46	Chair Railings	2000	6,267	418	15	418		1,703	46
47	Cove Base	2000	1,797	180	10	180		719	47
48	Constr. Of 400 Wing - Design, Architecture & Engineering	2001	67,723	2,709	25	2,709		9,481	48
49	Constr. Of 400 Wing - Contractor Costs	2001	943,708	37,748	25	37,748		132,119	49
50	Constr. Of 400 Wing - Drawings, Surety Bond & Misc.	2001	11,223	449	25	449		1,571	50
51	Constr. Of 400 Wing - Interest & Mortgage Ins. Premiums	2001	89,316	3,573	25	3,573		12,505	51
52	400 Wing Nurse Call System	2001	10,104	674	15	674		2,358	52
53	400 Wing Cable TV System Cabling	2001	1,962	196	10	196		686	53
54	400 Wing Fire Alarm System	2001	14,696	980	15	980		3,429	54
55	400 Wing Telecommunication System	2001	4,025	402	10	402		1,408	55
56	400 Wing Door Monitor System	2001	2,640	264	10	264		924	56
57	400 Wing TV Wall Mounts	2001	6,030	603	10	603		2,110	57
58	400 Wing Signage	2001	1,161	232	5	232		812	58
59	400 Wing Hand Rails & Wall Guards	2001	2,319	155	15	155		541	59
60	400 Wing Chair Rails, Wallpaper & Border	2001	4,208	842	5	842		2,946	60
61	400 Wing Door Guards	2001	607	121	5	121		424	61
62	400 Wing Cubicle Tracks & Curtains & Window Treatments	2001	15,188	1,962	5-20	1,962		6,868	62
63	Landscaping, Shrubs & Trees	2001	11,744	1,174	10	1,174		4,404	63
64	Fencing	2001	4,200	525	8	525		1,925	64
65	Wallpaper & Border - Existing Facility	2001	55,671	11,134	5	11,134		43,834	65
66	Storage Building	2001	3,268	327	10	327		1,253	66
67	Carpet - Administrative Offices	2001	2,687	537	5	537		2,060	67
68	Nurse Call System - Existing Facility	2001	3,700	247	15	247		884	68
69	Alarm System Services - Existing Facility	2001	3,903	260	15	260		1,041	69
70	TOTAL (lines 4 thru 69)		$ 2,723,612	$ 130,801		$ 130,821	$ 20	$ 961,414	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,723,612	$ 130,801		$ 130,821	$ 20	$ 961,414	1
2	Replacement Signage - Existing Facility	2001	3,656	731	5	731		2,803	2
3	Door Guards - Existing Facility	2001	1,979	396	5	396		1,418	3
4	Vinyl Flooring & Cove Base 400 Wing	2001	11,615	1,162	10	1,162		4,065	4
5	25 Overbed Lights	2001	1,625	162	10	162		555	5
6	Painting Door Frames	2001	8,932	1,786	5	1,786		6,699	6
7	2P 50 Amp Disconnect	2001	955	48	20	48		163	7
8	Mini Blinds, Valances & Rods	2001	14,744	2,949	5	2,949		9,338	8
9	Asphalt Paving of Parking Lot	2001	14,193	1,419	10	1,419		5,204	9
10	A/C Units	2001	3,424	342	10	342		1,214	10
11	Overbed Lights	2002	3,055	305	10	305		869	11
12	Cubicle Curtains	2002	6,155	1,231	5	1,231		3,402	12
13	2 A/C Units	2002	1,398	140	10	140		373	13
14	Security Camera System	2002	1,010	202	5	202		505	14
15	Fire Doors	2002	1,543	103	15	103		257	15
16	Roofing - North Entrance	2002	1,680	168	10	168		364	16
17	Wall Guard & End Caps	2002	1,497	100	15	100		216	17
18	Door Canopy	2003	3,800	253	15	253		507	18
19	Landscaping	2002	1,729	173	10	173		389	19
20	Home Office Light Fixtures	2002	212		10	21	21	62	20
21	Landscaping, Plants, Trees	2003	18,903	1,890	10	1,890		2,669	21
22	A/C Units	2003	5,551	555	10	555		851	22
23	Home Office Cabinets	2003	918		10	92	92	138	23
24	Landscaping, Plants, Trees	2004	4,371	255	10	255		255	24
25	100 Amp Transfer Switch to Generator	2004	11,865	593	15	593		593	25
26	Smoke Detectors	2004	1,600	107	10	107		107	26
27	Extend Activities Wall/Replace Door	2004	2,002	89	15	89		89	27
28	Air Conditioners	2004	1,814	91	10	91		91	28
29	Cove Base	2004	2,188	109	10	109		109	29
30	Hollow Metal Double Doors	2004	8,520	35	20	35		36	30
31	Wall/Flooring-Kitchen	2004	2,983		10				31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,867,529	$ 146,195		$ 146,328	$ 133	$ 1,004,755	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 259,045	$ 24,344	$ 25,249	$ 905	5-20	$ 108,150	71
72	Current Year Purchases	31,738	2,465	2,650	185	3-10	2,650	72
73	Fully Depreciated Assets	292,416	782	914	132	5-10	292,416	73
74								74
75	TOTALS	$ 583,199	$ 27,591	$ 28,813	$ 1,222		$ 403,216	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	2000 Dodge Grand Caravan	2000	$ 24,916	$ 4,672	$ 4,672	$	4	$ 24,916	76
77	Home Office Admin	2000 Ford Taurus	2000	5,241		873	873	4	5,241	77
78	Home Office Admin	1998 Jaguar	2004	4,945		618	618	4	618	78
79	Home Office Admin	2001 Infiniti	2004	2,892		663	663	4	663	79
80	TOTALS			$ 37,994	$ 4,672	$ 6,826	$ 2,154		$ 31,438	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,560,386	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 178,458	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 181,967	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,509	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,439,409	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	None	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? N/A YES N/A NO

16. Rental Amount for movable equipment: $ 2,917 Description: Copier $2,323; Postage Machine $594
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Section Not Applicable		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a,8	5351 hrs	$ 137,056		$	$ 226	5,351	$ 137,282	1
2	Licensed Speech and Language Development Therapist	10a,8	1208 hrs	43,879				1,208	43,879	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,8	4604 hrs	111,746			183	4,604	111,929	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				157,086		157,086	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	X-Ray Other (specify): Lab Fees	39,3 39,3				14,802 19,768			14,802 19,768	13
14	TOTAL			$ 292,681		$ 34,570	$ 157,495	11,163	$ 484,746	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 332,299	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 35,043)	622,069		3
4	Supply Inventory (priced at cost)	10,321		4
5	Short-Term Investments			5
6	Prepaid Insurance	48,633		6
7	Other Prepaid Expenses	1,690		7
8	Accounts Receivable (owners or related parties)	447,713		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,462,725	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	30,300		12
13	Land	156,526		13
14	Buildings, at Historical Cost	2,777,475		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	593,097		16
17	Accumulated Depreciation (book methods)	(1,418,369)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	93,032		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Loan Costs	156,833		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,388,894	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,851,619	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 267,881	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1		29
30	Accrued Salaries Payable	83,399		30
31	Accrued Taxes Payable (excluding real estate taxes)	23,475		31
32	Accrued Real Estate Taxes(Sch.IX-B)	48,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Stockholder	50,000		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 472,756	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	23,398		39
40	Mortgage Payable	3,613,430		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,636,828	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,109,584	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (257,965)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,851,619	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (596,993)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (596,993)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	339,028	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 339,028	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (257,965)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,501,966	1
2	Discounts and Allowances for all Levels	(853,814)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,648,152	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	9,662	5
6	Therapy	739,350	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 749,012	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	12,638	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,767	13
14	Non-Patient Meals	493	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	179,284	19
20	Radiology and X-Ray	10,318	20
21	Other Medical Services	33,132	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 237,632	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,086	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,086	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Machine Income	1,555	28
28a	Miscellaneous Income	2,573	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,128	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,640,010	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	784,603	31
32	Health Care	1,870,943	32
33	General Administration	839,825	33
	B. Capital Expense		
34	Ownership	558,505	34
	C. Ancillary Expense		
35	Special Cost Centers	191,656	35
36	Provider Participation Fee	55,450	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,300,982	40
41	**Income before Income Taxes (line 30 minus line 40)****	339,028	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 339,028	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Not yet filed **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,103	2,217	$ 48,605	$ 21.92	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,178	9,935	184,900	18.61	3
4	Licensed Practical Nurses	19,499	20,385	329,556	16.17	4
5	Nurse Aides & Orderlies	74,499	77,995	680,683	8.73	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,428	3,860	37,073	9.60	8
9	Activity Director					9
10	Activity Assistants	3,940	4,329	36,927	8.53	10
11	Social Service Workers	4,758	4,811	57,528	11.96	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,962	25,706	178,001	6.92	15
16	Dishwashers					16
17	Maintenance Workers	3,751	4,100	43,859	10.70	17
18	Housekeepers	12,089	12,852	87,422	6.80	18
19	Laundry	11,106	11,567	81,773	7.07	19
20	Administrator	2,209	2,281	73,467	32.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,320	4,759	53,520	11.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,910	2,113	22,878	10.83	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	176,752	186,910	$ 1,916,192 *	$ 10.25	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	167	$ 5,017	1,3	35
36	Medical Director	N/A	9,600	9,3	36
37	Medical Records Consultant	24	1,116	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	N/A	1,500	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,449	11,3	44
45	Social Service Consultant	24	1,449	12,3	45
46	Other(specify)				46
47	Quality Assurance Nurse	N/A	16,480	10,3	47
48	MDS Consultant	N/A	1,650	10,3	48
49	TOTAL (lines 35 - 48)	239	$ 38,261		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ Section N/A		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45. ** See instructions.

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Terrie Weible	Administrator	0.00	$ 73,467
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 73,467

B. Administrative - Other

Description	Amount
Wellington Management Company - Management Fees	$ 167,890
Health Care Financial, L.L.C. - Management Fees	65,794
TOTAL (agree to Schedule V, line 17, col. 3)	$ 233,684
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, L.L.C.	Accounting Fees	$ 48,236
Hughes & Associates	Audit Fees	5,890
McMahon, Berger, Hanna, et al	Legal Fees	468
Scott W. Shultz	Legal Fees	25
Ted Frapolli	Legal Fees	27
Duane Morris	Legal Fees	5,475
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 60,121

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 65,554
Unemployment Compensation Insurance	16,019
FICA Taxes	138,552
Employee Health Insurance	32,940
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Disability Insurance	768
Employee Dental Insurance	(580)
Staff Relations	9,154
Home Office Employee Benefits	12,118
TOTAL (agree to Schedule V, line 22, col.8)	$ 274,525

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Section Not Applicable		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,680
Advertising: Employee Recruitment	11,303
Health Care Worker Background Check	
(Indicate # of checks performed 29)	388
Licenses & Fees	1,644
Dues & Subscriptions	1,890
Service Charges	1,689
IHCA Dues	3,721
Home Office Dues & Subs	477
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,792

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,454
Seminar Expense	1,922
Home Office Travel & Seminar	11,491
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,867

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	Schedule Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Assoc.-$3,721**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **10,559** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **55,450**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **None**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **493**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **11%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Hughes & Associates** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

JERSEYVILLE NURSING AND REHABILITATION CENTER, INC.
RECLASSES
ATTACHMENT TO SCHEDULE V
12/31/2004

DESCRIPTION	LINE #	INCREASE (DECREASE)
ADMINISTRATIVE	17	(1,886)
BARBER & BEAUTY SHOPS	40	344
ACTIVITIES	11	1,169
TRAVEL & SEMINAR	24	250
NURSING & MEDICAL RECORDS	10	123

To reclass various expenses to proper lines

JERSEYVILLE NURSING AND REHABILITATION CENTER, INC.
MISCELLANEOUS INCOME
ATTACHMENT TO SCHEDULE XVII, PAGE 19, LINE 28a
12/31/2004

EMPLOYEE FLU SHOTS	385
MEDICAL SUPPLIES REIMBURSEMENTS	607
DIETARY FOOD REIMBURSEMENTS	434
OTHER MISCELLANEOUS INCOME	1,147
	2,573

JERSEYVILLE NURSING AND REHABILITATION CENTER, INC.
TRAVEL AND SEMINAR SCHEDULE
ATTACHMENT TO SCHEDULE XIX PART G
12/31/2004

SEMINAR PARTICIPANT	JOB TITLE	DATE(S)	CITY	TITLE OF SEMINAR	SPONSOR	COST	SEMINAR LODGING/MEALS
Various	Various	9/2004	Springfield, IL	2004 IHCA Convention	IHCA	298	505
Terrie Weible	Administrator	3/29-3/30/04	Springfield, IL	2004 Annual IL Nursing Home Administrator Convention	INHAA	95	
Marcy Ballard	DON	5/19/2004	Springfield, IL	DAVE-Is Your Facility at Risk	IHCA	80	
Fannie Stewart	MDS Coordinator	5/19/2004	Springfield, IL	DAVE-Is Your Facility at Risk	IHCA	80	
Terrie Weible	Administrator	5/25/2004	Bridgeton, MO	9th Annual Resident Rights Conference	LTC Ombudsmen Program	80	
Jenny Stewart	Social Services	5/25/2004	Bridgeton, MO	9th Annual Resident Rights Conference	LTC Ombudsmen Program	80	
Terrie Weible	Administrator	11/2003	Peoria, IL	Nursing Home Administrators Seminar	INHAA	75	
Mark Weible	Therapy Director	11/11/2004	Peoria, IL	Dawning of a New Era-Convention	INHAA	75	
Kay Powell	Dietary	8/20/2004	Carrollton, IL	Dietary Refresher Course	Green County Health Dept	25	
Terrie Weible	Administrator	6/16-6/17/04	Peoria, IL	INHAA Quarterly Meeting	INHAA	75	
Diana Ohley	Social Services Director	6/24/2004	St. Louis, MO	Healthcare Marketing Skills & How to Use Them	Cross Country University	149	
Terrie Weible	Administrator	8/11/2004	Springfield, IL	IL Medicaid Reimbursement System	IHCA	90	
Jenny Stewart	Social Services	8/11/2004	Springfield, IL	IL Medicaid Reimbursement System	IHCA	70	
Cindy Bloodworth	Activities	8/11/2004	Springfield, IL	IL Medicaid Reimbursement System	IHCA	70	
Terrie Weible	Administrator	11/10-11/11/04	Peoria, IL	Dawning of a New Era-Convention	INHAA	75	
						1,417	505

Seminar Lodging/Meals	505
Home Office Travel & Seminar	11,491
Other Travel <$250 Each	4,454
Total Travel & Seminar, Line 24	17,867